Response to CMS
Formal California IHSS Plus Demonstration
Request for Additional Information (RAI)
June 3, 2004

Eligibility

1. **It is CMS' understanding that the IHSS Plus eligible population will be determined Medi-Cal eligible under State plan procedures. Please prepare a plan and timeline by which determinations will be made.**
   Response: IHSS Plus waiver enrolled individuals will be reevaluated over the course of the next year during annual Medi-Cal redetermination or whenever the case requires a change of assessment, whichever comes first.

2. **FFP will not be available for unqualified aliens or those subject to the 5-year bar. However, the state may continue to cover these individuals through State-only funds or may discontinue their participation from the IHSS.**
   Response: We agree that unqualified aliens or those subject to the 5-year bar are not eligible for Medi-Cal coverage, except for emergency services, including labor and delivery are eligible for federal financial participation (FFP). If during the transition from the IHSS Residual Program to the IHSS Plus waiver, these individuals are identified as receiving personal care services, such services will be funded by the State. If necessary, FFP will be returned to CMS.

3. **SSI procedures for determination of presumptive disability will need to be followed. Please describe the State's process for presumptive disability, including usual timeframes in which a disability determination is made.**
   Response: The Medi-Cal rules and timeframes apply. Medi-Cal follows the SSI process for determining presumptive disability. Regular Medi-Cal rules will be followed by Medi-Cal eligibility workers (EWs) in determining Medi-Cal eligibility for individuals requesting services under the IHSS Plus Waiver, including presumptive disability (PD). Medi-Cal follows the SSI program rules for PD.

   a. **Is there a significant difference in the number of those found eligible for presumptive eligibility/services and those found later to not qualify when the final disability determination is made?**
      Response: Under the IHSS Plus waiver, the Medi-Cal PD criteria will be applied. Most individuals who are granted PD qualify for disability status.

   b. **If a person is found not disabled, how and when is the eligibility stopped?**

Response: First, all avenues are explored for eligibility under any of the Medi-Cal programs. If no Medi-Cal eligibility option exists, eligibility stops at the end of the month in which the disability denial is received. A timely notice that Medi-Cal benefits will discontinue is sent to the recipient.

c. **Are there any circumstances under which the person could remain eligible for services, i.e., in the residual program?**
Response: Yes, if the State retains a small, State-only program.

4. **The State's proposal indicates that persons who were once eligible for SSI but who are now ineligible because of engaging in SGA (substantial gainful activity) are currently eligible for the residual program. Are these same individuals eligible for Medi-Cal—are they 1619(a) or (b), Ticket or Buy-in?**
Response: If an SSI individual in the waiver converts to 1619(a) or (b) status, then he/she will continue on Medi-Cal automatically as required by federal law. If SSA reports to us that he/she is now ineligible for SSI/SSP, 1619(a) or 1619(b) due to SGA, the State follows all existing Medi-Cal requirements to exhaust all avenues of Medi-Cal eligibility, including the 250 Percent Buy-In program before discontinuing the individual from Medi-Cal coverage.

5. **The State's proposal has requested an effective date of January 1, 2004. The proposal states that eligibility for Medi-Cal is determined by county Medi-Cal eligibility workers who make eligibility decisions using current Medi-Cal eligibility rules. However, the draft All County Welfare Director's Letter (ACWDL) (Appendix 7) refers to ABD-MN cases, A& D FPL cases, and 250% WD cases, and states "Counties must ensure that these Medi-Cal eligibility determinations are being made by Medi-Cal eligibility workers effective July 1, 2004."**
Response: This ACWDL is a restatement of existing policy that Medi-Cal determinations are to be processed by Medi-Cal EWs. The draft letter was written in response to CMS' request, that California, once again, provide clarification to county staff to ensure that county Medi-Cal EWs do the Medi-Cal determinations.

a. **Who is making the eligibility determination for residual cases prior to July 1?**
Response: County social workers have been making eligibility determinations for residual cases to date. With approval of the waiver, Medi-Cal eligibility will be made by county Medi-Cal eligibility workers.

If the waiver is approved, the counties will move all IHSS Residual recipients without a Medi-Cal primary aid code into 1D, 2D, or 6D while awaiting a Medi-Cal reevaluation under other Medi-Cal programs. This

means that if the waiver is approved, all currently eligible IHSS recipients will continue to receive full scope Medi-Cal eligibility until they are reevaluated under all other Medi-Cal programs before their eligibility may be discontinued. Since this is the only purpose for this full-scope aid code series it could be switched from an FFP aid code to a state-only aid code if we determine the need to do that. That question will need a legal evaluation.

The re-determination of any remaining IHSS Residual recipients into regular Medi-Cal will occur in a flow basis over a course of one year.

b. **When was the process changed, or has it been changed, from the prior practice which employed non-Medi-Cal workers to make these eligibility determinations?**
Response: The process has not changed for the Residual population, but will change upon approval of the waiver.

6. **DSS MPP-30-701 (d) 1 references "deeming of certain relatives living in the household". Please describe who is included in the term "certain relatives".**
Response: For the waiver, the definition of relatives follows SSI and former AFDC rules. Medi-Cal financial responsibility and budget unit determination rules apply.

7. **Please define the terms (i.e., headings in columns and rows) used in the Eligibility Matrix furnished by the State.**
Response: See attached chart.

8. **How does the table on page 6 of the proposal, depicting IHSS RP users and target populations, jibe with the Elgibility Matrix the State furnished subsequently? Please explain the differences in the numbers in these documents.**
Response: The two sets of numbers represent snapshots of the same population at two different points in time and represent two slightly different ways of depicting the population. The snapshot on page 6 of the proposal is from February 2004 data and the numbers on the eligibility matrix are from March 2004 data. The table on page 6 also does not include the approximately 4,000 beneficiaries in the "Unknown" category. The eligibility matrix defines members of each sub-group as unduplicated as possible, i.e., if a beneficiary is part of the current IHSS Residual population for more than one reason such as being both Advance Pay and receiving Protective Supervision, that case is counted in the "Multiple Reasons" category rather than reported once for each reason.

9. **DSS MPP 30-755 1.12 references those "currently institutionalized". Please clarify whether "currently institutionalized" includes persons institutionalized in an IMD.**
   Response: Medi-Cal rules apply. Individuals unconditionally released from an IMD and who meet the Medi-Cal eligibility criteria may be eligible to receive in-home services.

10. **How are the IHSS participants similar or different from the Medi-Cal PCSP? For example, are they less or more disabled, based on ADL/IADL needs? What percentage of IHSS RP participants meets the functional eligibility requirements for the State Plan PCSP? Do all the people in the IHSS RP qualify for the State Plan PCSP?**
    Response: IHSS Plus waiver participants are similar to PCSP participants because each one needs assistance with ADLs and/or IADLs. As a group, IHSS Plus waiver participants are neither more or less disabled. IHSS Plus waiver participants have chosen services or service delivery options that previously were not available under Medi-Cal; e.g. Protective Supervision, Advance Pay, Family Caregivers, Domestic Services only and/or Restaurant Allowance. The needs assessment for both programs is the same. **What percentage of IHSS RP participants meets the functional eligibility requirements for the State Plan PCSP?** 100% of the IHSS RP participants meet the disability and functional eligibility requirements as outlined in the State Plan, they must have a chronic, disabling condition that causes functional impairment that is expected to last at least twelve consecutive months or that is expected to end in death within 12 months and who is unable to remain safely at home without the services. **Do all the people in the IHSS RP qualify for the State Plan PCSP?** People in the IHSS Plus waiver would qualify for the State Plan PCSP if they opted for services or needed services that are covered under the Medi-Cal State Plan. Prior to the IHSS Plus waiver, these individuals were covered under the IHSS Residual Program because they do not have a direct or hands-on personal-care need, had protective services needs, and/or they opted for family caregivers or advance pay.

11. **Would individuals who currently receive personal care services under the State Plan PCSP have the option to enroll in the IHSS Plus Demonstration program? And, vice versa, could individuals enrolled in the IHSS Plus Demonstration program elect to receive personal care services via the State Plan PCSP? Please explain.**
    - **Response:** Recipients in the PCSP, who meet the IHSS Plus Demonstration program eligibility criteria, will have the option to enroll in the IHSS Plus Demonstration program. For example, recipients in the PCSP do not have the option of hiring a parent or spouse provider. Eligible PCSP recipients wishing to have a parent or spouse provider may elect to enroll in the IHSS Plus Demonstration program.

Eligible participants in the IHSS Plus Demonstration program will be able to transfer to the PCSP.

Spend-down and Share of Cost Determinations

12. **We expect standard Medicaid cost determinations (e.g., spend-down and share of cost) (SOC) to be made. We understand that the IHSS populations are Medically Needy populations, however, Appendix 7 deviates from federal Medicaid rules for determining spend-down. If the State is envisioning a waiver of Medicaid rules to accomplish what is set forth in Appendix 7, then there will need to be further discussions and a new budget model developed for the demonstration. Please compare and contrast what is currently being done under Medi-Cal to what is proposed in Appendix 7, and include in your response, answers to the following:**

a. **The draft letter in Appendix 7 provides instructions for expanding personal care services to the ABD-MN, the A&D FPL group, and the 250% Working Disabled group. Do these instructions apply to other medically needy groups?**
Response: PCS was implemented for the ABD-MN program on April 1, 1999. PCS was made available for the A & D FPL and 250 Percent Working Disabled programs when the programs were implemented.

b. Are personal care services available to non-ABD medically needy recipients?
Response: No, not for AFDC MNs. PCS are available for the categorically needy including the A & D FPL program and the 250 Percent Working Disabled program and became available when the programs were implemented.

c. The State proposes a payment "buy-out" to CMS from the state general fund when a converted ABD-MN PCS recipient's SOC is greater than his IHSS SOC. The recipient pays the lower SOC. However, buy-out is not allowed under the Medicaid program. It should also be noted that payment of the spend down is not a condition of Medi-Cal eligibility. Please reconcile the practice with Medicaid and Medi-Cal requirements.
Response: The State proposes, under the waiver, to cover share of cost individuals as "state only" until they provide proof of incurring services; certify their share of cost at the beginning of each month so that the

individuals may still receive other services and drugs; and implement an interface to send information from CMIPS to MEDS when the proof of incurring services is provided by the beneficiary. Then, when the share of cost is met, change the beneficiary from "state only" status to FFP and claim the federal dollars.

d. **The proposal states that payment of the entire obligated SOC is a condition of eligibility for IHSS. How is IHSS eligibility handled when the individual meets his SOC by incurring other medical expenses? Please share the rationale for having different SOC methodologies for these (IHSS/PCSP and/or residual) individuals. Does it vary by program or service? The proposal goes on to state that IHSS will be terminated if the recipient fails to pay the entire obligated SOC within the month it is obligated. This is not consistent with Medicaid spend down policy. Per 42 CFR 435.831(d), medical expenses need only to be incurred, not fully paid, to be considered in meeting SOC. Section 30-768.24 states that if a recipient does not pay his obligated SOC, the county should initiate recovery for the entire amount of the IHSS payment for the month the person was ineligible. Please reconcile the practice with Medicaid and Medi-Cal requirements.**
Response: Medical expenses may paid be or incurred to meet the Medi-Cal share of cost. Under the waiver, federal share of cost/spenddown rules will apply.

e. **Please explain if failure to pay the entire obligated SOC within the month takes into consideration special life circumstances when a payment is missed.**
Response: Under the waiver, Medi-Cal share of cost rules apply. See above.

f. **Please explain assessed needs in relationship to example 2 on page 46. Please clarify the last paragraph of the example that explains the treatment of assessed needs. Could a MN individual qualify for personal care under the state plan personal care option?**
Response: Yes

13. **The draft refers to "Sneede" and "Gamma"case decisions. Since these cases deal with impermissible deeming, does the waiver cover AFDC-related medically-needy individuals? In the explanation of the "target population" the State mentions only ABD medically-needy. Please clarify.**
Response: No, the IHSS Plus waiver does not cover AFDC-related Medically Needy individuals. However, the Sneede and Gamma court decisions also apply to the Section 1931(b) program and the waiver. The

IHSS Plus waiver covers both ABD-Medically Needy and Categorically Needy individuals.

Compliance, Claiming and Reimbursement

14. **Much of what is in Appendix 5 and Appendix 6 appears to be out of date. What are the current standards used in the IHSS program?**
Response:
    - The IHSS RP is governed by state law found in Welfare and Institutions Code Section 12300 et seq. (Appendix 6). These statutes are not out of date.
    - To be eligible for the IHSS RP, an individual must meet all income and resource rules that govern the SSI/SSP program as reflected in 20 CFR Part 416, except countable income may be higher than SSI/SSP limits, and they need to meet the immigration-status criteria that existed for SSI/SSP on August 8, 1996.
    - Some of the income and resource rules in the IHSS RP regulations, Appendix 5 (CDSS MPP 30-700 et seq.), have not been updated to reflect SSI/SSP changes.
    - CDSS has issued to counties Income and Resource Reference Guides that reflect current SSI/SSP rules.
    - Clarification of the immigration status for the IHSS RP was issued to counties by All-County Information Notice I-23-99.

15. **It is expected that State Plan polices and procedures will govern. Please prepare a plan and timeline by which all IHSS/PCSP policies and procedures that differ from State Plan Medicaid policies will be updated, including spend-down and share of cost policies and procedures, recovery of overpayments for non-PCSP payments, exemption of motor vehicle provisions and disposal of assets provisions (inclusion of liquid assets unclear.)**
Response: The intent is to have the IHSS RP mirror PCSP. The State Plan Policies and Procedures will be used. Where there is a conflict, federal statutes and regulations will prevail. Legislation is being drafted to allow the IHSS RP to conform with all federal requirements where necessary.

16. **There is a concern about the potential for duplication of services and duplication of payments, resulting in overpayments and erroneous claiming of FFP. How will the State monitor, particularly given the existing systems limitations and the lack of system(s) interface that currently exist? (e.g., the current inability to interface with MMIS or Medi-Cal Eligibility Data Systems (MEDS); Caseload Management Information and Payroll System (CMIPS II) Draft Proposal showing implementation of needed systems changes 2008-2009.) Please**

provide a plan describing how the State will properly track, pay and report claims.

Response: As appropriate for IPWP, the State will replicate the existing process for tracking, paying and reporting claims in the PCSP. In the next several months the State will be designing and implementing several additional interfaces to more efficiently and effectively obtain paid claim information contained in the MMIS or MEDS and provide that information to the State QI Monitoring staff and/or the counties as is necessary. As an example, one of the proposed new interfaces will result in a CMIPS alert to the counties that the beneficiary had been in out of home care enabling the county to change the status of the case to avoid future payments and to seek timely reimbursement of any monies already paid. One opportunity for a duplication of services exists when a beneficiary is admitted to the hospital or skilled nursing facility and a provider also submits claims for payment during the same time period. The current CMIPS also includes the functionality to track and report overpayment collections and to make adjustments to the funding sources to avoid erroneous claiming of FFP.

17. **Section 30-700.3 states: "Individuals who qualify for both IHSS and PCSP funding shall be funded by PCSP." Please explain what this means.**

Response: This regulation section is born from Welfare and Institutions Code Section 12300(g), which provides that persons who are eligible to receive a personal care or ancillary service under the PCSP are not eligible to receive that service under the IHSS RP.

The purpose of this section is to ensure that persons who are eligible for services under the federally-funded PCSP receive their services under PCSP, and not under the county/state-funded IHSS RP.

Persons who are otherwise eligible for the PCSP, but elect to receive advance pay, or to have a parent or spouse provider, are therefore not eligible for PCSP and would be served under the IHSS RP.

18. **Is it anticipated that persons will be able to participate in more than one waiver—for example, the proposed IHSS+ and HCBS waivers, or IHSS+ and Personal Care State Plan services? If so, please describe how participation in more than one program works, providing examples of combinations such as Residual and Personal Care State Plan (PCSP) participation, Residual and HCBS waiver participation, Personal Care State Plan services and HCBS participation.**

Response: Yes. One example would be an individual in the DHS Nursing Facility (NF) HCBS waiver who is getting some nursing services and some personal care services. Currently, a spouse or parent provider could not be paid to provide PCSP. With waiver approval, the recipient can continue

receiving nursing through the NF HCBS waiver and receive personal care from his/her provider of choice, reimbursed through this waiver.

Another example would be an individual in the IHSS RP waiver who could get a Personal Emergency Response Device through the NF waiver.

The social worker, the plan and the timesheet reconciliation process prevents duplication. If an individual qualifies for another of the States HCBS waivers, close coordination occurs between the county social worker and the case manager of waiver services.

Budget Neutrality

19. Please provide answers to the following based on the budget data furnished May 10, 2004:

a) **Were non-Medicaid eligible individuals' costs included in the historical data, the member months and in the projections?**
Response: No.

b) Were non-Medicaid eligible individuals' member months included in the historical data?
Response: No.

c) **According to the methodology description, impacted state plan services include personal care services, DME, and home health agency services. What number or percentage of the current IHSS recipients receives these services? Response:** The percentage of IHSS residual program individuals that received DME or a Home Health Agency service in June 2003 was: DME = 6.4% and HHA = 1.1% **The 5/10/04 data from the State include separate amounts for impacted and IHSS RP self-directed expenditures. Have there been adjustments to the data since 5/10/04? Response:** no

d) **What is the average cost of personal care services for persons in the State Plan PCSP, excluding those who receive services under the IHSS RP. What is the growth rate for these services using the same timeframe used in the proposal (1999 to 2001)?**
Response: To be provided

e) **Growth in expenditures from 1999-00 through 2002-03 seems mostly to be due to cost per person increases (MM trend is low). This is an unusual cost trend for a personal care program. It seems to affect both Impacted and RP services. 17% is high rate to show for 199-00 through 2009 – ten years. What is the cause – severity changes? Assessment changes? Hourly reimbursement changes – minimum**

wage changes? More premium wages (payments over minimum occurring? Response: To be provided

f) **Please explain the expenditure and participation experience data for each component of the IHSS RP (Legally responsible family members, advanced pay, meal allowance, domestic services, protective supervision and multiple components)? Would the PMPM cost be adversely affected if some of these components are not available for FFP under section 1115 authority? Will the State be willing to walk us through the costs for services under each component? Response:** To be provided

20. Worker's Compensation costs are paid directly to the State Compensation insurance fund and have not been included in provider rates. The proposal states that the provider rate only covers wages and benefits, employer taxes, and administration. How are insurance costs to be incurred and claimed?
Response:

- The social worker is notified by the provider that an injury has occurred. The social worker submits the appropriate forms to SCIF within 7 calendar days. SCIF obtains the necessary medical and/or investigative documentation for the review process of the claim and sends an acknowledgement letter to the provider within 14 calendar days of notification from the social worker that an injury has occurred. Based on approval of the claim, SCIF provides workers compensation benefits to the provider.

- SCIF provides payment for all approved workers compensation claims to the respected providers and submits an invoice to CDSS for 100% reimbursement costs.

- CDSS reimburses SCIF 100% of the cost through a contract between CDSS and SCIF.

- CDSS submits an invoice for reimbursement to DHS for the federal cost portion of the program.

- The remaining non-federal portion of costs is State and County shared. The State invoices the county for the county share of the costs on a monthly basis.

21. Please discuss all budget changes to the IHSS program, or that impact the IHSS program, proposed for 2004-2005 SFY, noting in particular whether the Governor's proposal to limit IHSS provider rates to minimum wage is still pending, and if so, how will it impact the waiver

submission with respect to budget neutrality information and workforce shortage.

Response: As you know, the Governor's Budget is a proposal and requires approval by the Legislature and must be signed by the Governor before the State budget can be adopted. While we cannot speculate what version of these proposals or if these proposals will be adopted, the proposal to limit IHSS provider rates to minimum wage has been rejected in both the Senate and Assembly sub-committees

22. **If the State of California cuts provider wages to minimum wage, will local or county governments cover the portion of provider wages not paid by the State?**

Response:

- This specific item, as currently proposed in the Governor's Budget, reduces the State participation and does not become effective until October 1, 2004, if passed, at which time the State will only share in the costs of wages at the minimum wage. Counties will need to determine if they wish to assume State's share of the cost to enable their current rate. To date, this proposal has been rejected in both the Senate and Assembly sub-committees.

- AB1682 requires each county to act as, or establish, an employer of record for IHSS providers for the purposes of provisions of statutory law regarding employer/employee relations. The employer/employee relations of public agencies, such as PA, are governed by the Meyers, Milias, Brown Act. The employer/employee relations of private entities, such as IHSS contractors, are governed by other labor relations laws including the National Labor Relations Act.

Public Notice Requirements

23. **Did the State post a notice of the intent to submit a demonstration proposal in newspapers of general circulation, giving individuals a mechanism for how they could receive a copy of the proposal and comment on the proposal? If so, please provide a copy of the notice.**

Response: The success of the State's effort to provide ample notice to stakeholders is clearly evident in the large number (over 90) of support letters submitted with the application. The state did not post a newspaper notice. The notice requirement was met through other methods. First, there were at least six hearings at the California Legislature that included substantial discussion regarding the waiver application. Each of these hearings was heavily attended by interested stakeholders. In addition to the public hearings, a draft of the waiver application was sent electronically to

interested stakeholders who then forwarded the information on to their networks reaching approximately 60,000 individuals. The Department of Health Services and the Department of Social Services also posted notices and a link to download the application from their web pages before the application was submitted.

Legislative Hearings:

April 22, 2004	Senate Budget & Fiscal Review Subcommittee No. 3 on Health, Human Services, Labor, & Veterans Affairs
May 17, 2004	Assembly Budget Subcommittee No 1 on Health and Human Services
May 20, 2004	Assembly Budget Subcommittee No 1 on Health and Human Services
May 20, 2004	Senate Budget & Fiscal Review Subcommittee No. 3 on Health, Human Services, Labor, & Veterans Affairs
May 22, 2004	Senate Budget & Fiscal Review Subcommittee No. 3 on Health, Human Services, Labor, & Veterans Affairs
May 21, 2004	Senate Budget & Fiscal Review Subcommittee No. 3 on Health, Human Services, Labor, & Veterans Affairs

A draft of the IHSS Plus Waiver application was sent out with a request for comments to the following multi-member networks:

Commissioners on Aging **Gray Panthers** **Protection and Advocacy, Inc. organizations**	25 commissioners
Coalition of Californians for Olmstead (COCO)	35 members
California Disability Community Action Network and Website	Over 50,000 members that include family members, people with developmental and other disabilities, community organizations, direct care, and in-home workers, advocacy groups, etc. IHSS Plus waiver application was also posted on their web page that gets approximately 1000 hits per day.
California Foundation for Independent Living Centers **State Independent Living Council** **Area 4 Agency on Aging** **State Legislative staff**	29 ILCs

The draft IHSS Plus waiver application or notification of the application was forwarded by the individual, group or network above to:

- AARP
- Association of Community Organizations for Reform Now
- Alzheimer's Association California Council
- American Parkinson's Disease Association
- Asian and Pacific Islander American Health Forum
- American Parkinson's Disease Association
- Association of Regional Center Agencies
- Bay Area and Western Paralyzed Veterans of America
- Brain Injury Policy Insititute of California
- California Disability Community Action
- California Alliance for Inclusive Communities
- California Association of Adult Day Services
- California Association of Area Agencies on Aging
- California Association of Public Authorities for IHSS
- California Black Health Network
- California Budget Project
- California Congress of Seniors
- California Council for the Blind
- California Disability Alliance
- California Foundation for Independent Living Centers
- California Governor's Committee Employment of People with Disabilities
- California Health Incentives Improvement Project
- California Network of Mental Health Clients
- California Pan-Ethnic Health Network
- Californians for Disability Rights
- Californians living Independently and Free
- CalTash
- Coalition for Housing Accessibility, Needs, Choices & Equality, Inc
- Congress of California Seniors
- Council of Seniors and Senior Organizations
- County Welfare Directors Association
- Disability Rights Advocates
- Disability Rights Education and Defense Fund, Inc
- Easter Seals of Southern California
- Ethnic Service Managers Assn
- Exceptional Parents Unlimited
- Faith in Action'
- Family Caregivers Alliance
- Home care Council
- IHSS Recipients and Providers Sharing

- Independent Living Services of Northern California
- Jay Nolan Community Services
- JERICHO
- Latino Coalition for a Health California
- MSSP Site Association
- National Senior Citizen's Law Center
- Northern California ADAPT
- Oakland Center for Independent Living
- Older Women's League of California
- Organization of Area Boards on Developmental Disabilities
- Paralyzed Veterans of America
- Parents Helping Parents
- People First of California, Inc
- Placer Independent Resource Services
- Rose Resnick Lighthouse for the Blind
- Service Employees International Union
- Support for Families of Children with Disabilities
- TACC Triple-A Council of California
- Team of Advocates for Special Kids, Inc
- The ARC San Francisco
- The Center for an Accessible Society
- UC Berkeley Center for Labor Researach and Education
- UCLA Labor Center
- UCSF Center for Persona Assistance Services
- Unification of Disabled Latin Americans
- United Advocates for Children of California
- United Domestic Workers
- Urban Counties Caucus
- Western Law Center for Disability Rights
- World Institute on Disability

24. **Did the State submit a notice to tribal organizations informing them of the proposed demonstration and requesting their comments? If so, please provide a copy of the notice.**
Response: Yes, the Letter of notification was sent to all California Tribal Organizations on April 29, 2004. An electronic copy is attached to this response to the CMS RAI.

Program Coordination

25. **Please define the term "disability" as used in the DSS MPP 30-755.23.231. Is this applied uniformly in all counties.**
Response: The term "disability" as used for the IHSS Plus waiver and for PCSP has exactly the same meaning as it does in the SSI program, and 42 CFR 435.540 and 435.541 and in 20 CFR, Part 416, Subpart I. This definition

is the same as for the Medi-Cal State Plan PCSP criteria for Medi-Cal disability determinations. This term is applied uniformly in all counties.

26. Please clarify the criteria for discontinuing services by the transferring county as this could otherwise result in unnecessary terminations by the county of origin. See MPP 30-759.95.
Response:

- The criteria for discontinuing services by the transferring county (county of origin) would be the same criteria used for discontinuing services, irrespective of the inter-county transfer that is in process. Examples of the criteria used for
  discontinuing services would be the recipient has moved out of state, has excess resources, or is no longer considered disabled.

- The purpose of the Inter-County Regulation Section (MPP 30-759.9) is to ensure there will be no interruption or overlapping of services as the result of an otherwise-eligible recipient moving from one county to another.

Quality Management System

27. The State's proposal notes that it will implement many activities in the development of a Quality Management System that incorporates the features of the Quality Framework. Please provide a plan and timeline for phasing in needed monitoring and reporting mechanisms so the State will be able to fully comply with the requirements of discovery, remediation and improvement. Please address the following activities, not intended to be exhaustive, in the plan:
a. **Some counties have no "emergency back up system."**
Response: Most counties with operational Public Authorities have a process which enables recipients to get immediate assistance in locating a provider in the event that a provider is no longer available. Severely impaired recipients have the option of request "advance pay", which is available statewide. The primary benefit of advance pay is that recipients have the option of being able to hire a provider and pay them directly in emergency situations. Most public authorities also have the ability to respond by providing immediate referrals in the event of an emergency. Many recipients, particularly those who receive services from family members, have emergency back up plans in existence. During assessments and reassessments, recipients are asked for the name and phone number of an emergency contact. This person or agency can be contacted to assist in identifying other resources in the event of an emergency or if the provider does not show up. The State will ask all counties to submit a procedure for responding to emergencies relating to provider unavailability by January 1, 2005.

b. Regarding the "incident management system": What about situations that are not within the purview of Adult Protective Services or other agencies? Are such incidents tracked? How?
Response: Incidents that are not within the purview of Adult Protective Services or other agencies are tracked at the local level by county staff. The incidents are currently tracked in the narrative portion of the case record where county staff document telephone calls and other contacts made by or on behalf of recipients.

c. **How will DHS gather participant data and incident reports (discovery) from the counties? Discovery includes collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.**
Response: DSS will provide DHS quarterly data on participants. DHS will review the data to identify trends and provide written requests for corrective action to DSS. Additionally, DHS will coordinate with DSS the implementation of technical assistance to the local area or statewide.

Discovery process for incident reports and direct participant experience will be developed in conjunction with DSS.

d. How will DHS oversee the remediation of identified problems? Remediation includes taking action to remedy specific problems or concerns that arise.
Response: As operational or program problems are identified, DHS will require corrective action plans (CAP) from DSS to resolve the problem. DHS will monitor the implementation of the CAP to determine that the plan has been followed and that it resolves the problem.

DHS may perform collaborative site visits with DSS or may perform independent visits to assess the management of reported incidents, specific issues or services.

e. How will DHS implement continuous quality improvement? Continuous improvement includes utilizing data and quality information to engage in actions that lead to continuous improvement.
Response: DHS and DSS will implement continuous quality improvement through the routine review of data and joint meetings to discuss the identified systems issues that need to be managed. The system issue may be managed through program policy development, training or other technical assistance. The goal of CQI is to assess the effectiveness and

functionality of the program so necessary changes can be planned and implemented in order to achieve the desired outcomes.

f. How will the State monitor that problems identified through the incident management system and the unusual event system are addressed and resolved in a timely and appropriate manner to protect participants?
Response: DSS will ensure that problems are addressed and resolved in a timely manner through review of case files during the Waiver monitoring visits to the County. DHS will ensure that appropriate resolution has occurred through monitoring of the results of the DSS monitoring.

g. Who pays for the criminal background check? Is it required in some situations or solely at the discretion of the recipient?
Response: The recipient pays for the criminal background check. In most cases it is solely at the discretion of the recipient; however, in some situations the Public Authorities require and pay for a Criminal background check prior to placing a prospective provider on the Registry.

h. The third paragraph on page 18 states that training and support procedures will be made available to participants and caregivers through the activities of the State's IHSS Enhancement Initiative Real Choice Grant 91549\9. What products from the grant activities will be made available to waiver participants and providers? What are the critical milestones, timelines and the current status for the development and implementation of these tools?
Response: All products from the grant activities will be made available to waiver participants and providers. See attached chart.

i. The chart describing DSS quality assurance activities (Page 16, row 2 of chart at bottom of page) indicates that onsite (county) review activities will include sampling of recipient outcomes and satisfaction. What procedures and tools will be used to effectively carry out this activity?
Response: DSS has been performing monitoring of the PCSP and IHSS residual program since 1993. Tools utilized in performing the monitoring have been provided as part of the Operational Protocol. We are also attaching a draft Manual that will be revised and finalized to incorporate any activities that are unique to the Waiver. The Manual and tools were developed in cooperation with a State/County workgroup. DSS will also review results of surveys conducted by Public Authorities.

j. The monitoring procedure entitled "Quality Improvement" (Page 17, last row) should specify who is responsible for carrying out QI

activities, procedures to be employed including the frequency and methodology of QI activities, and products to be achieved as a result of these processes. Response: DSS is preparing a monitoring plan that will include information regarding who is responsible for carrying out QI activities. We are also in the process of developing procedures to be employed that include the frequency and methodology of QI activities. The Waiver monitoring activities will be coordinated with the enhanced monitoring of the PCSP program by DSS staff. We anticipate that the plan will be available by October 1, 2005.

k. A procedure for on-site monitoring. Would the State evaluate and consider use of a call-in monitoring program by the care provider, such as that used by South Carolina?
Response: We are not familiar with the call-in monitoring program by the care provider used by South Carolina and, therefore, cannot respond as to whether this system would be appropriate for a state as large as California. However, it is our intention to explore new technologies that can assist in quality assurance activities at the State and county level.

l. What activities are contingent on the approval of the proposal for a new Caseload Management Information and Payroll System (CMIPS II) and development of improved MMIS?
Response: Although the specifics of the QI activities and how CMIPS/MMIS data will be used are still under development, the approval of the CMIPS II will allow more effective and efficient sharing and availability of data currently available only in either the CMIPS or the MMIS. Although some data such as death dates is shared, it is not available to CMIPS until long after the fact. Other data is shared only by special request requiring complicated, labor-intensive data matches. Without approval of CMIPS II, these slow, out-dated and ineffective processes will not change.

Through integration with MMIS, the PCSP/IPWP claims information (both Individual Provider and County Contractor) will be included with the other MMIS subsystem data to provide a more comprehensive picture of the claims paid for all services covered by the State plan and the waiver. This information will be made available to the QI monitoring staff through regular reports and by easy-to-use querying capabilities.

Also, integration with MMIS will help prevent incorrect payments for recipients who are hospitalized or deceased. Currently, the social worker may not know when a recipient is hospitalized and should not be receiving any in-home services. Social Workers have to depend on the recipient, provider, family or discharge social worker to notify them of the

hospitalization. Through the MMIS interface, they will be able to be notified of admission date, discharge date, discharge destination or death.

CMIPS II will provide management reports to administer and oversee the PCSP/IPWP programs. By integrating CMIPS II data with the other MMIS subsystems, the state will have a more comprehensive data set for the entire State plan and waiver by including the PCSP/IPWP for the MARS and SURS functions.

m. **What additional DHS resources will be required and requested?**
Response: DHS has requested five additional positions through the formal budget process. The additional positions have been approved by both the Senate and the Assembly Budget Committees. One position is for formal waiver support, three are for oversight and fiscal monitoring, and one is for accounting and fiscal tracking.

Self-Directed Services/Benefits and Service Delivery Options

28. The proposal sets forth the roles and responsibilities of the Public Authorities. What are the roles and responsibilities of the Nonprofit Consortia, Joint Powers Agencies and County IPs?
Response:

- A Non-Profit Consortium is a group of two or more non-profit service agencies that join together as one entity to contract with a county to administer the IHSS program and direct the delivery of services to IHSS recipients. The responsibilities of a non-profit consortium are set forth in WIC Section 12301.6 and are identical to those of the Public Authority.

- Joint Powers Agencies or Regional Service Agreements are authorized by AB 1682 that authorizes counties to join together to form regional agreements for the purpose of establishing an employer of record for their IHSS workers. All the requirements for a PA would still have to be met.

- County IP's means that a county with over 500 cases will have to establish an employer of record for providers who may continue to work as Individual Providers. The employer of record may be established by using a Public Authority, Non-Profit Consortium or directly administering the Individual Provider mode of service delivery.

29. Do participants have the option of being the Employer of Record? If so, under what modes of service delivery? For those participants who wish to be the Employer of Record, please describe all information and

assistance given to them to fulfill their fiscal and employment-related functions.

Response: No, participants do not have an option of being an Employer of Record. AB 1682 requires each county to act as, or establish, an employer of record for IHSS providers for the purposes of provisions of statutory law regarding employer/employee relations. WI&C 12302.25 (a) Participants (recipients) of In-Home Supportive Services shall retain the right to choose the individuals that provide their care and to recruit, select, train, reject, or change any provider under the contract mode or to hire, fire, train, and supervise any provider under any other mode of service.

"Employer of Record" is used to designate the employer in a formal employer/employee relationship and is the designated entity that interacts with the provider workforce in the manner referenced in WI&C Section 12302.25.

30. **Please clarify to whom and how transportation is provided under the IHSS RP. DSS MPP 30-757.154.**
Response:

- Assistance with transportation is provided only to recipients in the IHSS RP, and only when such assistance is necessary to accomplish the travel.
- Assistance with transportation is available only to medical and medically-related appointments, and to sites where alternative resources are provided (e.g. to an adult day center where the recipient will receive a bath and noon-time meal).
- Assistance with transportation can be provided in all modes of transportation, including automobiles and public transportation.

31. **Please clarify whether "Teaching and Demonstration Services" referenced in DSS MPP 30-757.181 can include family members or neighbors as "persons who ordinarily provide IHSS".**
Response: Yes, family members and neighbors can be included as "persons who ordinarily provide IHSS" under MPP 30-757.181.

32. **Can the persons to be served in the IHSS Plus program be working? Please explain.**
Response: Yes, PCSP and IHSS Plus waiver coverage is available to those who assessed to need services either in their homes or at their workplace. The state implemented the 250% Working Disabled Program and passed state legislation for persons with disabilities to receive IHSS/PCSP services in the workplace. A State Plan Amendment was approved in 2003. California also received its Ticket to Work in November 2003.

33. **Please clarify whether respite care is provided, or will be provided under the demonstration program, in any "out of home care facility" referenced in DSS MPP 30-701 (o) 1.**
Response: Respite care coverage under either PCSP or the IHSS Plus waiver is allowed through the arrangement of an alternative caregiver, using the assessed number of hours on the service plan. No services, including respite, will be provided under the waiver program in any "out of home care facility."

34. **Please clarify where personal care services can be provided. Are criminal background checks available to all individuals in the IHSS RP? If not currently available, please prepare a plan and timeline for when they will be available.**
Response:
- Yes, criminal background checks are available to all recipients in the IHSS RP. Welfare and Institutions Code Section 15660(a) allows all recipients of IHSS and PCSP to request a criminal background check through the California Department of Justice.
- MPP 30-753.23 - .231(b) Any Public Authority or Nonprofit Consortium shall provide the minimum service of: Investigation of the qualifications and background of potential providers listed on the registry.
- WI&C 12301.6 which governs PA, requires a PA to investigate provider qualifications, establish a referral system, and establish a provider registry.
- Contractor Mode and Homemaker Mode are not required or mandated to provide criminal background checks on their Individual Providers; however, some of those counties provide some kind of form of background checks.

35. **County and Public Agencies track and handle provider no-show and recipient at risk – please describe all activities related to the response to provider no-show and recipient at risk other than 911? Would the State consider adding 24/7 contract or employed assistance for critical events that would otherwise place a client in jeopardy –case mangers on call 24/7 and/or individual and program back up plans?**
Response: DSS wishes to call attention to the fact that not all persons who receive services under the IHSS program are at risk in situations when a provider does not show up on a short term basis. For example, persons who receive help with only domestic and related services may not be at risk if their provider does not show up for one or two visits, or longer in some circumstances. In these cases, the temporary absence of the provider does not place the recipient at risk. Furthermore, when the recipient has

established a relationship with the current provider and is happy with the services, the necessity to change providers for a short term absence is stressful for the recipient. During State reviews, recipients are asked questions regarding provider dependability, and most report that they do not have a problem with providers not showing up. They also report that if the provider does not show up on a scheduled day, they usually make up the time on another day. A large percentage of recipients receive services from family members and, in our experience, would be more likely to have a backup plan when a provider is unavailable for a short period of time. We believe this would be particularly true in the case of spouses and parents of minor children who are providing services. Of the IHSS population, advance pay recipients would be the group who are most severely impaired and would be most at risk if a provider did not show up. Inasmuch as a primary benefit of advance pay is to give the severely impaired person the opportunity to immediately hire someone in an emergency, the possibility of this group being at risk is minimized. Our experience has been that the group who receives advance pay is, of necessity, very skilled at interviewing and scheduling providers, and in most cases, maintain their own list of available providers who can be called when a provider does not show up.

Some Public Authorities have staff available 24 hours per day 7 days per week to respond to emergencies related to provider no shows and some contract with other agencies to provide emergency backup. Due to budget constraints, the state must carefully consider any proposals that would increase program costs, but are open to working with CMS, the counties and Public Authorities in addressing this issue.

36. **Is an assessment completed for each participant of what may place each participant at risk of harm, including the failure of the participant's care provider to show up? Is there a contingency plan developed that would manage or resolve the risk? If not currently available, please prepare a plan and timeline for when individual risk assessment and contingency planning would be available.**
Response: To be submitted

37. **Is there a system-wide contingency plan in the event the participant's contingency plan fails and the participant is placed at risk of harm? If not currently available, please prepare a plan and timeline for when a system-wide contingency plan would be available.**
Response: To be submitted

38. **Please describe the qualifications of the social workers. Please describe the roles and responsibilities of the social workers. Please include in your answer whether the social workers have any of the following**

responsibilities: monitoring quality of care b) assisting participants with learning their employer and/or fiscal related responsibilities c) accessing other needed supports in the community (outside of the IHSS Plus program) d)acting as a point of contact if participants have questions or their care providers are unavailable. Response: Qualifications of social workers vary from county to county. County staff performing assessments are involved in the monitoring of the quality of care. Typically this occurs during the re-assessment process through observations and questions. Social workers are responsible for:

- Completing assessments for applicants in the home and in nursing homes, hospitals etc.
- Informing recipients of their rights and responsibilities
- Assisting recipients as needed in establishing their eligibility and need for services
- Correctly determining ability and need in their assessment of the recipient.
- Evaluating the capacity of recipients to discharge their responsibilities for reporting and providing documentation as required.
- Complying with administrative standards to insure timely processing of recipient requests for service.

Monitoring quality of care

Social workers are responsible for insuring that program funds allocated for services are being spent appropriately and that services authorized are actually provided and that the recipients needs are being met to allow them to safely remain in their home..

Assisting participants with learning their employer and/or fiscal related responsibilities

Social workers at the time of their initial home visit to the recipient's home will ask that the provider be present. The social worker will explain the recipient's role as an "employer" and provide program brochures that the recipient and provider can read, such as information on workers compensation, recipient and provider responsibilities, provider benefits, I-9 responsibilities etc.

Accessing other needed supports in the community (outside of the IHSS Plus program)

Social workers will refer recipients to the Multi-Senior Services Program (MSSP) for other needed services, Regional Center Services, other waiver program services, EPSDT.

Acting as a point of contact if participants have questions or their care providers are unavailable.

Social workers at the time of the initial home visit will provide the recipient and provider with the telephone number of the county IHSS office and of their assigned social worker and their work hours.

39. **Please describe how participants who do not make a complaint to the Department of Mental Health or the Department of Developmental**

Services Office of Clients Rights Advocacy are able to access an independent advocate/advocacy service?
Response: To be provided

40. **How are participants in IHSS assisted in providing the needed "training" to their personal care assistants?**
Response: In 23 of the 58 counties, state funds (Supported Individual Provider (SIP)funds are made available to provide recipient training on how to be the employer of their IHSS Plus waiver or PCSP provider. The Public Authorities, Non Profit Consortiums and Joint Powers Agreement counties provide for access to training, and some have set up training programs for their registry providers.

41. **Substitute Payee-DSS MPP 30-701 (s) (9): Please clarify whether "substitute payee" includes the fiscal intermediary. If not, please explain whom it may include.**
Response: Substitute payee does not include the fiscal intermediary. Substitute payee is a person designated by the IHSS RP recipient, and is usually a relative or close friend of the recipient.

When an IHSS RP recipient chooses to receive Advance Pay (direct payment) and needs assistance with their financial affairs, the substitute payee receives the advance payment, and pays for the services, on behalf of the recipient.

42. **Please define "full-time employment" as referenced in DSS MPP 30-763.45.451(a): ("When the recipient is under eighteen years of age and is living with the recipient's parent(s)"…and parent left "full time employment".)**
Response: Full-time employment is generally considered to be 40 hours or more per week. Exceptions to this rule can be made by county social workers. For instance, if the parent's employer reasonably considers the parent to be a full-time employee, and treats him/her as such, then the parent may be considered to be employed full time.

43. **Please explain who is a qualified provider when a recipient is under 18, as referenced in DSS MPP 30-763.45.452. ("a suitable provider" is any person who is "willing, available, and <u>qualified</u>".)**
Response: A suitable provider is any person who the recipient (or in their responsible parent's judgment or spouse's judgment) wants and identifies as qualified to provide the services that the recipient needs to allow him/her to remain safely in his/her own home. Whether the person is qualified depends on the type of IHSS needed. For example, if the IHSS service is laundry, the person would have to be capable of performing laundry services in order to be considered qualified to provide the needed IHSS.

44. **Please provide examples of alternative resources that may be used as referenced in DSS MPP 30-763.61. Please explain how possible errors in use of inappropriate care are avoided.**
Response: Examples of alternative resources would include the Multi Services Senior Program (MSSP), a California Department of Aging program; Adult Day Centers; and Meals on Wheels.

    In accordance with the above regulation, County Social Services staff ensure that the alternative resources available from other agencies or programs meet the assessed needs of the recipient. In addition, social services staff arrange for the delivery of such alternative resources.

45. **Please explain why compensation is a county-based rate and not one identified by the recipient. DSS MPP 30-764.2.**
Response: Compensation to providers is a county-based rate determined through collective bargaining. Individual recipients of IHSS are not in a position to collectively bargain.

46. **Please explain how each county's availability of personal care attendants is factored into the determination of a payment rate to a parent or spouse as a personal care attendant. DSS MPP 30-766.**
Response: MPP 30-766 references County Plans, and does not contain a reference to personal care attendants. The availability of personal care attendants is not a factor in the determination of payment rates.

Evaluation

47. **There are no anticipated savings, and no new services, nor is the State expanding eligibility. What is the evaluative component of this demonstration project?**
Response: The primary program objective is to continue to provide access to service options that permit increased consumer control and satisfaction. The IHSS Plus waiver services and delivery options are not currently available under Medi-Cal State Plan PCSP. The evaluative component is to continue to keep the population in their homes and communities.

Funding Questions

48. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking the State to confirm to CMS that providers in the IHSS Plus §1115 Demonstration program would**

retain 100 percent of the payments. Would the State, through the IHSS Plus §1115 Demonstration program, participate in activities such as intergovernmental transfers or certified public expenditure payments, including the Federal and State share; or, would any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If the IHSS Plus §1115 Demonstration program providers would be required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)
Response: To be provided

49. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state's share of the Medicaid payment for the IHSS Plus §1115 Demonstration program would be funded. Please describe whether the state's share would be from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and State share amounts for the Medicaid payment. If any of the state share would be provided through the use of local funds using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the state verifies that the expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b).**
Response: The non-federal share of PCSP and IHSS Plus Waiver services is divided between State General Fund allocations through the DSS budget (65%) and local county funding allocations (35%).

50. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments would be made, please provide the total amount for each type of supplemental or enhanced payment made to IHSS Plus §1115 Demonstration program.**
Response: There will be no supplemental or enhanced payments for services made in the IHSS Plus Demonstration program.

51. ***This is applicable to inpatient hospital, outpatient hospital and clinic services.*** **Please provide a detailed description of the methodology *to be* used by the state under the demonstration program to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).**
Response: ***Not Applicable.***

52. **Would any public provider receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**
Response: Payments to public providers are for wages and benefits only, and do not include per diem, DRG, fee schedule, global, supplemental, enhanced or other payments. No public provider would receive payments that, in the aggregate, exceed its reasonable costs of providing services.

Response to Question 7
ELIGIBILITY MATRIX DEFINITIONS

ROWS DOWN LEFT SIDE OF MATRIX

Advance Pay Option	The number of participants who are included in the IHSS Residual Program solely because they receive the value of their services grant in advance and pay their provider directly. All other aspects of the case are PCSP eligible.
Domestic Services (No Personal Care Services)	The number of participants who are included in the IHSS Residual Program solely because they do not receive any federally eligible services.
Spouse/Parent Caregiver	The number of participants who are included in the IHSS Residual Program solely because their services are provided by a spouse or they are a minor recipient whose parent provides their services.

Protective Supervision	The number of participants who are included in the IHSS Residual Program solely because they receive Protective Supervision, a non-federally eligible service. These cases are often "split" cases where other services are provided under the PCSP.
Unknown	This group is made up of participants who generally fall into one of two categories. They are cases that are coded "N" for not PCSP-eligible even though their case appears to be PCSP eligible, or they are cases currently without a provider associated to the recipient. This is believed to be a transient group always being worked by the counties.
Multiple Reasons for Residual	Whereas the participants in the groups above are included in each category as their single reason for IHSS Residual eligibility, this group is made up of participants who are in the IHSS Residual Program for multiple reasons, e.g., the case is served by a spouse and also receives advance pay or the case is served by the parent of a minor who is providing Protective Supervision.

Response to CMS
Formal California IHSS Plus Demonstration
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June 3, 2004
COLUMNS ACROSS TOP OF MATRIX

# Medi-Cal Eligible	The number of IHSS Plus Waiver Program participants who are eligible for Medi-Cal
# SSI Eligible	The number of IHSS Plus Waiver Program participants who are eligible for SSI.
# Rec'g PCSP Services	This category was not completed because the IHSS Plus Waiver Program participants are those who are receiving IHSS Residual services. If they receive some services through PCSP, they are included in the column for Both PCSP + Residual.
# Rec'g HCBS Wvr Srvs	The number of participants receiving Home and Community Based waiver services.
Residual Only	The number of participants receiving services through the IHSS Residual Program and do not qualify to receive any services through the PCSP.
Both PCSP + Residual	The number of participants receiving part of their services through the PCSP and part of their services through the IHSS Residual Program. These are most often participants who qualify for PCSP but receive Protective Supervision through the Residual Program. These are also called "split" cases.
Protective Supervision	The number of participants included in the IHSS Residual program who receive Protective Supervision.
Domestic Services	The number of participants included in the IHSS Residual program who receive domestic services.
Respite Services	This category was not completed because the current IHSS Residual Program does not authorize Respite as a specific service category.
Restaurant Meals Allowance	The number of participants who have cooking facilities but cannot use them because of their disability and elect to receive Restaurant Meals Allowance in lieu of Meal Preparation and Clean-up.

Spouse Caregiver	The number of participants included in the IHSS Residual Program who receive services from their spouse
Parent Caregiver	The number of participants in the IHSS Residual Program who are minors receiving in-home supportive services provided by their parent.
Advance Pay Option	The number of participants in the IHSS Residual Program who receive the value of their grant in advance and pay their providers directly.
SGA> 1619(a)+(b) levels	This column was not completed because CMIPS does not collect this information.
Presumptively Disabled	The number of participants in the IHSS Residual Program who are presumed disabled. This number represents the number of participants with a status code "I" for Interim Eligibility in CMIPS.
Non-qualified Alien	This column was not completed because we have not determined conclusively the number of participants who should be included.
Not at INSTL LOC	The number of IHSS Residual Program participants determined not to be at an Institutional Level of Care based on a 1 to 5 ranking of the participant's level of risk without IHSS. This number includes those ranked "1" – Would remain at home and not be at risk and "2" – Would remain at home and be at risk. Not included are "3" – Would require NMOHC, "4" – Would require nursing level of care and "5" – Would lose employment.
Other	This column was not completed because the Waiver Team could not identify any participants not included in at least one of the other columns.

Response to CMS
Formal California IHSS Plus Demonstration
Request for Additional Information (RAI)
June 3, 2004

Timeline for Consultant Activities, Real Choice Systems Change Grant

		FY 03/04										FY 04/05												FY 05/06			
		Sep-03	Oct-03	Nov-03	Dec-03	Jan-04	Feb-04	Mar-04	Apr-04	May-04	Jun-04	Jul-04	Aug-04	Sep-04	Oct-04	Nov-04	Dec-04	Jan-05	Feb-05	Mar-05	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct--05
Inventory Existing Training Material	Task force meeting to define education and training needs and priorities and to identify existing educational and training material		TFM																								
	Inventory existing training material																										
	Task force meeting to review inventory of existing educational and training material												TFM														
Needs Assessment	Plan needs assessment focus groups																										
	Task force meeting to review plan for needs assessment focus groups			TFM																							
	Conduct needs assessment focus groups																										
	Conduct phone interviews																										
	Analyze results of focus groups and phone interviews																										
	Prepare needs assessment report																										
	Present needs assessment report to task force										TFM																
New Tool Development	Task force meeting to identify educational and training material that needs to be developed													TFM													
	Develop new educational and training material																										
	Task force meetings to review material being developed and provide feedback														TFM		TFM		TFM								
	Plan material evaluation focus groups																										
	Conduct material evaluation focus groups																										
	Evaluate and revise educational and training material																										
	Task force meeting on focus group results and revisions																							TFM			

Training for Trainers	Develop draft training for trainers plan																										
	Task force meeting to plan the training for trainers outreach																								TFM		
	Revise plan and schedule training sessions																										
	Conduct training for trainers																										
Final Report	Prepare final report																										
	Concluding task force meeting																										TFM